BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **HARVEY D. ZELIGMAN, M.D.** Holder of License No. 8173 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-11-1417A **ORDER FOR LETTER OF REPRIMAND AND CONSENT TO THE SAME**

Harvey D. Zeligman, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 8173 for the practice of allopathic medicine in the State of Arizona.

3. The Arizona Medical Board ("Board") initiated case number MD-11-1417A after receiving correspondence from Benson Hospital indicating that serious concerns arose in eight cases involving Respondent, including concerns regarding his alleged failure to perform basic tasks during work ups of his patients in the emergency department (ED).

4. Four patients' charts were obtained and reviewed by a Medical Consultant (MC) for a quality of care review. The MC identified multiple deviations from the standard of care in all cases as well as medical recordkeeping violations.

5. Patient BR, an 83 year-old female, presented to the ED complaining of abdominal pain. She had a known history of narcotic use for pain control and constipation.

According to Respondent, he only visualized two of the three views of the abdomen that were obtained. There was evidence of bowel obstruction on the x-ray. BR was discharged with a diagnosis of constipation.

6. Patient AD, a 23 year-old male, presented to the ED with suspicion of suicidal ideation and poly-pharmacy overdose. AD admitted to significant alcohol consumption as well as both Topamax and Ambien ingestion. He was initially extremely combative requiring restraints. AD was given Romazicon despite recommendations from poison control to withhold this medication and that administration would lower seizure threshold. Nasal intubation was attempted and unsuccessful resulting in a severe bloody nose. Indications for intubation were not documented and AD was transferred.

7. Patient DC, a 49 year-old female with a history of diabetes, presented to the ED complaining of back pain. Reproducible right-sided flank pain was noted on exam, and DC was noted to be hypertensive, tachycardic and febrile. She had an initial blood sugar of 350 with a subsequent blood sugar of 418. DC was diagnosed with a lumbar strain and discharged with pain medications. She was instructed to take her insulin as soon as she got home.

8. Patient BL, a 69 year-old male, presented to the ED complaining of right-sided weakness. He had a previous pacemaker placed a week prior and was on Coumadin. BL had a questionable history of a previous CVA. A wide complex rhythm was noted on EKG without easily identified pacer spikes. There was no previous EKG to compare the study to. BL was discharged with a diagnosis of transient ischemic attack, and there was no mention of the renal insufficiency, abnormal EKG, or hyperkalemia that were revealed by the labs and obtained EKG study.

9. The Staff Investigational Review Committee ("SIRC") met on July 12, 2012, and determined that Respondent should participate in a PACE evaluation based upon

concerns raised in this investigation. SIRC was concerned about Respondent's fund of knowledge, particularly with regard to the practice of emergency medicine.

10. On October 8-9, 2012, Respondent participated in Phase I of PACE, where his performance was varied. He performed poorly on the Microcog Cognitive Screening test, so PACE recommended that Respondent obtain a complete neuropsychological evaluation and complete Phase II of PACE. On January 16, 2013, Respondent was issued an Interim Order to undergo a neuropsychological evaluation.

11. The neuropsychologist determined that it is within a reasonable degree of neuropsychological certainty that Respondent's level of neuropsychological functioning is within normal limits. Respondent was subsequently issued an Interim Order to complete Phase II of PACE as recommended by the evaluators involved in Phase I.

12. On March 18-22, 2013, Respondent participated in Phase II of PACE. Respondent's PACE evaluators determined that his overall performance during Phase II was satisfactory, and he was deemed to have passed with recommendations. During Respondent's time with the emergency medicine faculty, he was found to have displayed good clinical judgment and was thought to have performed at an extremely high level. During his time with the family medicine faculty, he received positive comments and performed satisfactorily. However, during Respondent's behavioral health interview, he displayed some anxiety and it was suggested that he would benefit from a stress management program or a brief course of psychotherapy.

13. The standard of care requires a physician to review all diagnostics and radiographs ordered, to confirm that x-rays and diagnostics are completed as ordered, to avoid administering magnesium citrate in the setting of bowel obstruction, and to admit or transfer a patient with bowel obstruction.

14. Respondent deviated from the standard of care by failing to review all diagnostics and radiographs ordered, failing to confirm that x-rays and diagnostics were completed as ordered, by administering magnesium citrate in the setting of bowel obstruction, and by discharging a patient with evidence of bowel obstruction on x-ray and a discharge diagnosis of constipation.

15. The standard of care requires a physician to recognize the indications and contraindications of Romazicon, to perform nasal intubation with proper indications, to utilize rapid sequence intubation medications, and to stabilize the airway of a patient prior to transfer.

16. Respondent deviated from the standard of care by failing to recognize the indications and contraindications of Romazicon, by performing nasal intubation, on the first attempt, without any other indication, by failing to utilize rapid sequence intubation medications, and by failing to stabilize the airway prior to transferring the patient.

17. The standard of care requires a physician to address grossly abnormal vital signs, evaluate for diabetic ketoacidosis in a febrile, tachycardic patient with hyperglycemia and known history of diabetes, to evaluate and address potential causes for fever and tachycardia, and to order a urine dip or urinalysis in a patient with flank pain and fever.

18. Respondent deviated from the standard of care by failing to address grossly abnormal vital signs, by failing to evaluate for diabetic ketoacidosis in a febrile, tachycardic patient with hyperglycemia and known history of diabetes, failing to evaluate and address potential causes for fever and tachycardia particularly in a diabetic patient with flank pain, and by failing to order a urine dip or urinalysis in a patient with flank pain and fever.

19. The standard of care requires a physician to recognize and address new onset renal insufficiency in a patient with multiple comorbidities, address abnormal EKG

findings, and to admit or transfer an elderly patient with a transient ischemic attack with multiple comorbidities, pacemaker placement from a week prior, with new onset of renal insufficiency, hyperkalemia, and an abnormal EKG.

20. Respondent deviated from the standard of care by failing to recognize and address new onset renal insufficiency in a patient with multiple comorbidities, failing to address abnormal EKG findings particularly in the setting of hyperkalemia and renal insufficiency, and by failing to admit or transfer an elderly patient with a transient ischemic attack, multiple comorbidities, pacemaker placement within the past week, new onset renal insufficiency, hyperkalemia, and an abnormal EKG.

21. In the case of patient BR, failure to recognize and address bowel obstruction could result in bowel perforation, surgical intervention, bowel resection with need for ostomy, or potential peritonitis and death.

22. In the case of patient AD, failed nasal intubation in an altered and intoxicated patient could have resulted in compromised airway, respiratory arrest and death. Administration of Romazicom in a poly-pharmacy overdose patient on chronic benzodiazepines may have resulted in seizure. Failure to stabilize the patient's airway prior to transfer may have resulted in respiratory failure and death.

23. In the case of patient DC, failure to recognize and address hypertension could result in any one of many manifestations of hypertensive emergency. Failure to recognize and address potential causes of tachycardia and fever could result in a failure to diagnose systemic inflammatory response or sepsis resulting in potential death. Failure to evaluate potential causes of flank pain in the setting of fever and tachycardia to include ordering a urinalysis or urine dip may result in misdiagnosis of a urinary tract infection or urosepsis potentially resulting in death. Failure to address hyperglycemia in a diabetic

patient with tachycardia and fever may result in misdiagnosis of diabetic ketoacidosis with the potential outcome of death.

24. In the case of BL, failure to recognize and address new onset renal insufficiency and early hyperkalemia could result in progression to permanent renal failure and dialysis. Unrecognized and untreated hyperkalemia could result in fatal cardiac arrhythmia. Failure to address an abnormal EKG may result in fatal arrhythmia, infarction, or death. Failure to admit or transfer a transient ischemic attack may result in subsequent embolic stroke.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public").

ORDER

IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 3rd day of OCTOBER, 2013.

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

Harvey D. Zeligman, M.D. DATED: Aug 25, 2013

EXECUTED COPY of the foregoing mailed this 3rd day of October, 2013 to:

Harvey D. Zeligman, M.D.
Address of Record

ORIGINAL of the foregoing filed this 3rd day of October, 2013 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Arizona Medical Board Staff